SERFF Tracking Number:	*ZURC-125376790*	*State:*	*Arkansas*
Filing Company:	*Empire Fire and Marine Insurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*CW PR 26276*		
TOI:	*17.2 Other Liability - Occurrence Only*	*Sub-TOI:*	*17.2022 Other*
Product Name:	*Professional Liability/Ambulance CW PR 26276*		
Project Name/Number:	*Professional Liability/Ambulance CW PR 26276/CW PR 26276*		

Filing at a Glance

Company: Empire Fire and Marine Insurance Company

Product Name: Professional Liability/Ambulance CW PR 26276	SERFF Tr Num: ZURC-125376790	State: Arkansas
TOI: 17.2 Other Liability - Occurrence Only	SERFF Status: Closed	State Tr Num: EFT $50
Sub-TOI: 17.2022 Other	Co Tr Num: CW PR 26276	State Status: Fees verified and received
Filing Type: Form	Co Status: Not Applicable	Reviewer(s): Betty Montesi, Edith Roberts, Brittany Yielding
	Author: Carole Amato	Disposition Date: 12/07/2007
	Date Submitted: 12/05/2007	Disposition Status: Approved
Effective Date Requested (New): 05/01/2008		Effective Date (New):
Effective Date Requested (Renewal): 05/01/2008		Effective Date (Renewal):

State Filing Description:

General Information

Project Name: Professional Liability/Ambulance CW PR 26276	Status of Filing in Domicile: Pending
Project Number: CW PR 26276	Domicile Status Comments:
Reference Organization:	Reference Number:
Reference Title:	Advisory Org. Circular:
Filing Status Changed: 12/07/2007	
State Status Changed: 12/07/2007	Deemer Date:
Corresponding Filing Tracking Number:	

Filing Description:

Empire Fire and Marine Insurance Company would like to begin marketing a Professional Liability policy as part of our Ambulance program. Currently our Ambulance Program offers a General Liability policy with an endorsement to extend coverage to emergency transport risks for Professional Liability. We are now filing coverage for this risk under a separate Professional Liability policy.

Please be advised that as of June 1, 2007 we became affiliated with ISO Professional Liability line of business for

Empire Fire and Marine Insurance Company and at that time we requested that they file on our behalf.

We are also submitting a new, proprietary endorsement and application for use with the Ambulance Program.

EM 4656 (09-06) Volunteer Worker(s) Professional Liability Coverage
This endorsement will be used with the Allied Health Care Providers Coverage form to provide coverage for Volunteer Workers.

EM 2088 (04-07) Ambulance and Emergency Technicians Application – Occurrence
This application will be used when writing the Ambulance Program. It contains questions related to commercial auto and liability lines of business. We are submitting the form as it will be attached to the Professional Liability portion of the policy.

We will be using ISO Coverage forms and rules for this program. We will use ISO mandatory, State Amendatory endorsements. We have included several Proprietary Rule pages which are either exceptions to ISO or are in addition to the ISO rules and rates.

With this filing, we are also including a Professional Liability Declarations page and a Schedule of Forms and Endorsements. These two forms may be used by other programs or policies as necessary:
• EM 3626 0906 Alliance Health Care Providers Professional Liability Declarations
• U-GL-619-A CW 1002 Schedule of Forms and Endorsements

We request an effective date of 5/01/2008.

Company and Contact

Filing Contact Information

Carole Amato, Supervisor	carol.amato@zurichna.com	
1400 American Lane	(847) 413-5235 [Phone]	
Schaumburg, IL 60196-1056	(847) 605-7768[FAX]	

Filing Company Information

Empire Fire and Marine Insurance Company	CoCode: 21326	State of Domicile: Nebraska

SERFF Tracking Number:	*ZURC-125376790*	*State:*	*Arkansas*
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Project Name/Number:	*Professional Liability/Ambulance CW PR 26276/CW PR 26276*		

13810 FNB Parkway
Omaha, NE 68154-5202
(402) 963-5000 ext. [Phone]

Group Code: 212
Group Name:
FEIN Number: 47-6022701

Company Type:
State ID Number:

SERFF Tracking Number:	*ZURC-125376790*	*State:*	*Arkansas*
Filing Company:	*Empire Fire and Marine Insurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*CW PR 26276*		
TOI:	*17.2 Other Liability - Occurrence Only*	*Sub-TOI:*	*17.2022 Other*
Product Name:	*Professional Liability/Ambulance CW PR 26276*		
Project Name/Number:	*Professional Liability/Ambulance CW PR 26276/CW PR 26276*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Empire Fire and Marine Insurance Company	$50.00	12/05/2007	16957183

SERFF Tracking Number:	*ZURC-125376790*	*State:*	*Arkansas*
Filing Company:	*Empire Fire and Marine Insurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*CW PR 26276*		
TOI:	*17.2 Other Liability - Occurrence Only*	*Sub-TOI:*	*17.2022 Other*
Product Name:	*Professional Liability/Ambulance CW PR 26276*		
Project Name/Number:	*Professional Liability/Ambulance CW PR 26276/CW PR 26276*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	12/07/2007	12/07/2007

SERFF Tracking Number:	*ZURC-125376790*	*State:*	*Arkansas*
Filing Company:	*Empire Fire and Marine Insurance Company*	*State Tracking Number:*	*EFT $50*
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TOI:	*17.2 Other Liability - Occurrence Only*	*Sub-TOI:*	*17.2022 Other*
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Disposition

Disposition Date: 12/07/2007
Effective Date (New):
Effective Date (Renewal):
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ZURC-125376790*	*State:*	*Arkansas*
Filing Company:	*Empire Fire and Marine Insurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*CW PR 26276*		
TOI:	*17.2 Other Liability - Occurrence Only*	*Sub-TOI:*	*17.2022 Other*
Product Name:	*Professional Liability/Ambulance CW PR 26276*		
Project Name/Number:	*Professional Liability/Ambulance CW PR 26276/CW PR 26276*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Form	Ambulance and Emergency Techinicians Application-Occurrence	Approved	Yes
Form	Allied Health Care Providers Professional Liaibility Declarations	Approved	Yes
Form	Volunteer Worker(s) Professional Liability Coverage	Approved	Yes
Form	Schedule of Forms and Endorsements	Approved	Yes

SERFF Tracking Number:	*ZURC-125376790*	*State:*	*Arkansas*
Filing Company:	*Empire Fire and Marine Insurance Company*	*State Tracking Number:*	*EFT $50*
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TOI:	*17.2 Other Liability - Occurrence Only*	*Sub-TOI:*	*17.2022 Other*
Product Name:	*Professional Liability/Ambulance CW PR 26276*		
Project Name/Number:	*Professional Liability/Ambulance CW PR 26276/CW PR 26276*		

Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Ambulance and Emergency Techinicians Application-Occurrence	EM 20 88	04 07	Application/Binder/Enrollment	New	0.00	EM2088 0407 Ambulance App Occur.pdf
Approved	Allied Health Care Providers Professional Liaibility Declarations	EM 36 26	09 06	Declarations/Schedule	New	0.00	EM3626 0906 Prof Dec for Ambulance.pdf
Approved	Volunteer Worker(s) Professional Liability Coverage	EM 46 56	09 06	Endorsement/Amendment/Conditions	New	0.00	EM4656 0906 Amb Prof Volunteer.pdf
Approved	Schedule of Forms and Endorsements	U-GU-619-A CW	10 02	Declarations/Schedule	New	0.00	U-GU-619-A CW 1002.pdf

Ambulance and Emergency Technicians Application - Occurrence

Applications Instructions:

- **Type or print clearly the answers to all questions of the application.**
- **If any question does not apply, please indicate with "N/A" or Not Applicable. (do not leave an answer blank)**
- **If additional space is needed to answer a question, attach a separate sheet of paper indicating the question number and page of this application.**
- **Include all requested attachments along with the completed application.**
- **This application must be completed, dated and signed by an officer of the Named Insured.**

OPERATIONS

1. Requested effective date of coverage: _____ / _____ / _____

2. Expiration date of current coverage: _____ / _____ / _____

3. Named Insured: (Please provide a list of all Named Insureds, description of Named Insured including percentage ownership, date acquired and prior acts date).

Name of Insured	Description	% Ownership	Date Acquired

Name of Business: _____

D.B.A: _____

Street Address: _____

Mailing Address: _____

City: _____ County: _____ State: _____ Zip code: _____

Website address: _____

Contact Person: _____ Title: _____

Non-Emergency Phone Number: ( ) - Fax Number: ( ) - E-mail: _____

4. Are you located in an area subject to flooding? ☐ Yes ☐ No
If Yes, please attach disaster plan.

5. Type of Business: ☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture ☐ LLC ☐ Association ☐ Governmental Unit ☐ Other _____

Please provide your FEIN: _____

6. Tax status: ☐ For Profit ☐ Not for Profit ☐ Government

7. **a.** Applicant is: (check all applicable boxes)
☐ State certified ☐ Medicare approved
☐ Association certified ☐ Other: _____

b. ☐ Accreditation Denied

c. Has the organization's license ever been revoked, denied, limited or surrendered? ☐ Yes ☐ No

8. Is your business a subsidiary or division of another company? ☐ Yes ☐ No
If Yes, please complete the information below:

Name of Company	Address	Existing Relationship

9. Type of Service (check all that apply):

- ☐ Private (Proprietary) Ambulance Service
- ☐ Public Ambulance Service
- ☐ City Owned & Operated
- ☐ County Owned & Operated
- ☐ Fire Department
- ☐ Rescue Squad
- ☐ Volunteer Ambulance Corps
- ☐ Hospital Based Ambulance Service
- ☐ First Responder Group
- ☐ Ambulette or Chair Car Service
- ☐ Hospital Owned and/or Operator Ambulance Service
- ☐ Other: _____

10. On what date was your business legally established? (mm/yy) _____ Number of years under current ownership: _____

11. Manager's Name _____
Length of time managing service _____

If answers to 10. and 11. are less than 3 years, please attach resume of manager.

12. Has your business had any change in ownership over the last 3 years? ☐ Yes ☐ No
If Yes, Please provide details. _____

13. Safety Manager Name _____
Phone Number: ( ) - _____ E-mail Address: _____

14. Is your business involved in any fund-raising activities? ☐ Yes ☐ No
If Yes, Please describe activities: _____

15. How many ambulance calls does your service handle per year? Emergency: _____ Non-Emergency: _____

16. How many paratransit/wheelchair calls does your service handle per year? _____

17.
a. Will any new services, operations or locations be added in the next 12 months? ☐ Yes ☐ No
b. Will any services, operations or locations be discontinued in the next 12 months? ☐ Yes ☐ No
c. Have any services, operations or locations been discontinued in the past 24 months? ☐ Yes ☐ No
If you answered Yes to any of the above please provide details: _____
d. Do you engage in any of the teaching or certification programs for ambulance attendants or EMTs? ☐ Yes ☐ No

18. Does your business perform the following?

- ☐ Mast Trousers
- ☐ Intubation
- ☐ Defibrillation
- ☐ IV Therapy including IV Monitoring
- ☐ EOA
- ☐ Basic Life Support

19. Does your business have a Medical Director? ☐ Yes ☐ No
If Yes, provide name: _____

20. How many employees (full-time, part-time, paid or volunteer) who provide patient care are certified?
(count each individual only once)

_____ EMT Basic
_____ EMT Intermediate/Advanced
_____ State Certified First Responder
_____ Paramedic
_____ CPR only
_____ **Total** number of Employees/Volunteers

_____ Current & Valid Advanced First Aid and/or American Red Cross Holder
_____ Other (explain): _____

AUTOMOBILE

21. What are the vehicle counts for the following classifications and dates?

Classifications	As of Today	Renewal Date 1 yr ago	Renewal Date 2 yrs ago	Renewal Date 3 yrs ago	Renewal Date 4 yrs ago
Ambulances					
Paratransit/Wheelchair					
First Responder					
Service (all other units)					
Totals					

22. Who dispatches your calls?
☐ 911 ☐ In-house by own employees/volunteers
☐ Outside Sources (explain): _____

23. If dispatching duties are performed in-house, please advise the following:
a. Is previous dispatching experience required for employment? ☐ Yes ☐ No
b. If Yes, how much is required? _____
c. Describe in-house training for dispatchers including length of training time involved: _____

24. Does your business screen calls to determine whether or not an ambulance will be dispatched? ☐ Yes ☐ No
If Yes, please attach a copy of written procedures.

25. **a.** Is a call report completed on each and every call? ☐ Yes ☐ No
b. Is a call report completed on each and every ambulance requested? ☐ Yes ☐ No
If No, please explain: _____

26. **a.** How often are your call reports reviewed for completeness, legibility and professional content? _____
b. Who reviews these reports? _____
Name Title

27. Indicate the number of hours your employees/volunteers
a. Work per shift: _____
b. Are off duty between shifts: _____

28. Does your service have any non-owned and/or leased property in its physical care, custody or control? ☐ Yes ☐ No
If Yes, are you responsible for any damage to such property? ☐ Yes ☐ No
Describe property, use and value: _____

Please attach a copy of lease or agreement.

29. Does your business have Workers' Compensation and Employer's Liability Coverage? ☐ Yes ☐ No
If Yes, does the policy cover both paid employees as well as volunteers? ☐ Yes ☐ No

If your business has this coverage, please advise the following:

Name of Workers' Compensation carrier: _____
Policy Number: _____ Policy Period: _____

Employer's Liability Limits	Bodily Injury by Accident	$ _____	Each Accident
	Bodily Injury by Disease	$ _____	Policy Limit
	Bodily Injury by Disease	$ _____	Each Employee

30. **a.** Is your business involved in mock disasters? ☐ Yes ☐ No
If Yes, how often: _____

b. Is your business the sponsor of these mock disasters or just a participant? ☐ Sponsor ☐ Participant
Briefly describe what is involved in the mock disasters: _____

31. Is your service involved in:

Air Ambulance Operations	☐ Yes	☐ No
Water Rescue Operations	☐ Yes	☐ No
Off-shore EMS	☐ Yes	☐ No
Activities or Operations other than EMS	☐ Yes	☐ No
Special Event EMS	☐ Yes	☐ No

If Yes, provide details: _____

32. What is the percentage of mileage radius for your business operations?

_____ % 0-50 miles _____ % 50-150 miles _____ % Over 150 miles

33. How many times per year do your vehicles travel into the Greater Metropolitan areas of these 30 cities listed below (Also complete the attached Supplementary Form – EMS Application)

_____ Atlanta	_____ Hartford	_____ Philadelphia
_____ Baltimore	_____ Houston	_____ Phoenix
_____ Boston	_____ Indianapolis	_____ Pittsburgh
_____ Buffalo	_____ Kansas City	_____ Portland
_____ Chicago	_____ Los Angeles	_____ St. Louis
_____ Cincinnati	_____ Miami	_____ San Antonio
_____ Cleveland	_____ Milwaukee	_____ San Diego
_____ Dallas	_____ Minneapolis	_____ San Francisco
_____ Denver	_____ New Orleans	_____ Seattle
_____ Detroit	_____ New York City	_____ Washington, DC

34. How often is a condition report completed on each ambulance and its equipment?

☐ by Run ☐ by Shift ☐ Daily ☐ Other (explain): _____

35. Who maintains your ambulance(s)?

Name of Company: _____

Address (street, P.O. box): _____

City, State, Zip code: _____

36. What is the maintenance schedule for ambulances?

Please describe: _____

_____

37. Are maintenance records kept in your files? ☐ Yes ☐ No

38. Are your vehicles always locked when unattended? ☐ Yes ☐ No

39. How much above the posted speed limit will your ambulances travel in a true emergency mode? _____

40. Does your business allow third parties (other than patient and personnel) to ride along in the ambulance? ☐ Yes ☐ No

41. **a.** When adding new drivers, does your service require previous ambulance driving experience? ☐ Yes ☐ No

If Yes, how much experience do you require? _____

b. How do you verify this experience? _____

42. **a.** Does your business obtain Motor Vehicle Reports (MVR's) on all drivers who are allowed to operate the vehicles within your fleet? ☐ Yes ☐ No

b. If Yes, what standards has your business established for what is an acceptable driving record?

(1) Number of tickets in the past three years? _____

(2) Number of accidents in the past three years? _____

(3) Combination of tickets and accidents in the past three years _____ tickets plus _____ accidents?

43. Does your business maintain up-to-date driver's files including annual Motor Vehicle Reports? ☐ Yes ☐ No

44. Does your business maintain accident files? ☐ Yes ☐ No

If Yes, how long do you keep these files? _____

45. Does your business maintain an Accident Review Committee? ☐ Yes ☐ No

If Yes, are disciplinary measures utilized when accidents are determined to be your driver's fault? ☐ Yes ☐ No

46. What are the established minimum age standards for Drivers? _____

47. Does your service provide an Ambulance Drivers Training Program ☐ Yes ☐ No
If Yes, which program(s) are drivers required to attend?
☐ Defensive Drivers Course: ☐ Film ☐ Hands-on Training
☐ Federal Emergency Vehicle Operators Course (EVOC)
☐ Highway Patrol Training
☐ Smith System Drivers Training
☐ In-house Drivers Training

Please provide details including the length of time involved in the training process for those new hires without Emergency Vehicle Driving Experience.

48. Does your service utilize any of the following monitoring systems:

Road Safety International	☐ Yes ☐ No
Drive Cam Systems	☐ Yes ☐ No
VDO North America/Argo	☐ Yes ☐ No
Fleet Boss	☐ Yes ☐ No
Davis Instruments	☐ Yes ☐ No
Silent Witness/Allsafe/Failsafe	☐ Yes ☐ No
GPS	☐ Yes ☐ No
Fitness for Duty	☐ Yes ☐ No

49. What is the total value of your *Portable Equipment Inventory? $ _____
Indicate Valuation Method: ☐ Replacement Cost ☐ Actual Cash Value
*Portable Equipment Inventory does not include towers, antennas, repeaters, and base station radio equipment.

PROFESSIONAL LIABILITY

50. a. Professional Liability Exposures (Please complete a separate sheet for each location)

Services Provided	Frequency	Percentage of all responses

b. Employees:

Types	Employed As Full-Time	Employed In Full-Time Equivalents	Contracted As Full-Time	Contracted In Full-Time Equivalents
Physicians				
Ambulance attendants				
Emergency Medical technicians				
Other Professional Employees _____				
All Other Employees				
TOTAL:				

51. Risk Management

a. Who coordinates the facility's risk management program:
Name: _____ Title: _____
Telephone number: ( ) - _____ E-mail: _____
Years of experience: _____ Reports to: _____

b. Is there a written, risk management plan that has been approved by the governing body? ☐ Yes ☐ No

c. Is the risk manager solely accountable and responsible for risk management? ☐ Yes ☐ No
If no, explain other responsibilities:

_____

d. Does the risk manager have access to legal counsel to discuss risk issues not directly related to a claim? ☐ Yes ☐ No

e. Does the risk manager participate in or maintain the following:

Claim Management	☐ Yes ☐ No	IRB Committee	☐ Yes ☐ No
Contract Review and Evaluation	☐ Yes ☐ No	Patient Satisfaction Results	☐ Yes ☐ No
Disclosure	☐ Yes ☐ No	Policy and Procedure Development/Review	☐ Yes ☐ No
Staff Education	☐ Yes ☐ No	Risk Management Committee	☐ Yes ☐ No
Formal link to quality management	☐ Yes ☐ No	Patient Safety Program and Committee	☐ Yes ☐ No
Incident/Occurrence reporting	☐ Yes ☐ No	Sentinel Event Investigation	☐ Yes ☐ No
Infection Control Committee	☐ Yes ☐ No		

52. Claims Management

a. Who, within the organization, is responsible for claims management activities?
Name: _____ Title: _____
Reports to: _____ Years experience: _____

b. Do you use a Third Party Administrator? ☐ Yes ☐ No
If Yes, please provide the name of the firm: _____

c. Do you have a procedure to manage protected information under attorney client privilege? ☐ Yes ☐ No

d. Do you have a procedure to manage protected health information pursuant to HIPAA and other privacy laws? ☐ Yes ☐ No

e. Do you have written procedures detailing the claims management process? ☐ Yes ☐ No

f. Do you have a Risk Management Information System? ☐ Yes ☐ No

g. Please list defense firms who currently represent you in professional liability matters:

_____

h. Do you have knowledge of any threatened or pending civil or criminal actions or litigation? ☐ Yes ☐ No
If yes, please provide details: _____

_____

53. Current Insurance Program

Policy Period	Coverage Type	Insurer	Limits of Liability	Deductible/ SIR	Premium

UMBRELLA

54. Current Excess/Umbrella Program – Schedule of Underlying Insurance

Coverage	Limits of Liability
Healthcare Professional Liability Insurer: _____ Policy Period: _____ Premium: _____ ☐ Occurrence ☐ Claims Made Retroactive Date:	_____ Per medical incident _____ aggregate Defense Costs: ☐ Erode Limits ☐ In Addition To Limits
Commercial General Liability Insurer: _____ Policy Period: _____ Premium: _____ ☐ Occurrence ☐ Claims Made Retroactive Date: _____	_____ Per Occurrence _____ aggregate Defense Costs: ☐ Erode Limits ☐ In Addition To Limits
Employee Benefits Liability Insurer: _____ Policy Period: _____ Premium: _____ ☐ Occurrence ☐ Claims Made Retroactive Date: _____	_____ Per employee _____ aggregate Defense Costs: ☐ Erode Limits ☐ In Addition To Limits
Employers Liability Insurer: _____ Policy Period: _____ Premium: _____ ☐ Occurrence ☐ Claims Made Retroactive Date: _____	_____ Per _____ _____ aggregate Defense Costs: ☐ Erode Limits ☐ In Addition To Limits
Automobile Insurer: _____ Policy Period: _____ Premium: _____ ☐ Occurrence	_____ Combined Single Limit Defense Costs: ☐ Erode Limits ☐ In Addition To Limits
Other Insurer: _____ Policy Period: _____ Premium: _____ ☐ Occurrence ☐ Claims Made Retroactive Date: _____	_____ Per _____ _____ aggregate Defense Costs: ☐ Erode Limits ☐ In Addition To Limits

55. Automobile Liability exposures (where applicable for umbrella coverage)

Vehicle Type	Number of Vehicles	Use	State(s) Garaged
Private Passenger			
Light Truck/Van (non-patient transport)			
Van/Small Bus (non-emergency patient transport)			
Bus			
Emergency Ambulance			
Other			

a. Are automobile passengers carried for a fee? ☐ Yes ☐ No

b. Are any of the units listed above not insured by underlying policies? ☐ Yes ☐ No
If yes, please explain: _____

c. Are any vehicles leased or rented to others? ☐ Yes ☐ No
If yes, please explain: _____

d. Please attach a description of any automobile liability (BI, PD, UM/ UIM) claim in excess of $10,000. Please submit currently valued auto loss runs with date of loss, date claim made, loss descriptions, indemnity paid and reserved, expense paid and reserved.

56. General Insurance Information

a. For claims made coverage, was extended reporting period, (i.e. tail coverage) purchased for any previous primary, umbrella or excess policy? ☐ Yes ☐ No
If yes, please provide details: _____

b. Has any insurance carrier ever cancelled, non-renewed or refused insurance coverage? (This question is not applicable in Missouri) ☐ Yes ☐ No
If yes, please provide details: _____

LIMIT OPTIONS

Note: If an Umbrella policy is desired, then $1,000,000 limits are mandatory on both the Automobile Liability, General Liability and Professional Liability policies. **Employment Related Practices Liability is not available.**

Automobile Liability Limits (check limit desired)

☐ $500,000 Combined Single Limit Bodily Injury and Property Damage
☐ $1,000,000 Combined Single Limit Bodily Injury and Property Damage

General Liability Limits (check limit desired)

☐ $500,000 any one claim/$1,000,000 annual aggregate
☐ $1,000,000 any one claim/$2,000,000 annual aggregate

Professional Liability Limits (check limit desired)

☐ $500,000 any one claim/$1,000,000 annual aggregate
☐ $1,000,000 any one claim/$2,000,000 annual aggregate

Is an **Umbrella Policy** desired? ☐ Yes ☐ No

☐ $1,000,000 each occurrence/$1,000,000 annual aggregate
☐ $2,000,000 each occurrence/$2,000,000 annual aggregate
☐ Other (list) _____

Deductible Options (check limit desired)

☐ $500 for Automobile Comprehensive, Automobile Collision and Portable Equipment (Inland Marine)
☐ $1,000 for Automobile Comprehensive, Automobile Collision and Portable Equipment (Inland Marine)
☐ $2,000 for Automobile Comprehensive, Automobile Collision and Portable Equipment (Inland Marine)

Is **Property Coverage** desired? ☐ Yes ☐ No If Yes, please attach a completed ACORD Property Application.

STATEMENT FROM APPLICANT

The applicant hereby agrees that the foregoing statements and answers are a true representation of all the facts and circumstances with regard to the risk to be insured to the best of the applicant's knowledge and the same are therefore made the basis of any policy of insurance issued. I hereby authorize the Zurich Financial Services Companies to release the information on this application and associated underwriting information.

NOTICE TO APPLICANT - PLEASE READ CAREFULLY

The applicant represents that the above statements are true and correct to the best of his or her knowledge and that no material or relevant facts have been suppressed or misstated and agree that the policy, if issued, will be issued on the reliance of such representations.

Receipt and review of this application does not bind the Insurer to provide this insurance.

The following paragraph is applicable to Professional Liability: It is agreed by the applicant and the Insurer that the particulars and statements made in this application, together with all attachments to this application and any other materials submitted to the Insurer (all of which attachments and materials shall be deemed attached to the policy as if physically attached thereto) shall be the representations of the applicant and the prospective Insureds. It is further agreed by the applicant and the prospective Insureds that this policy, if issued, is issued in reliance upon the truth of such representations that are incorporated into and made part of this policy. After inquiry of all prospective Insureds, the undersigned authorized officer of the applicant represents that the statements set forth in this application and its attachments and other materials submitted to us are true and correct. Signing of this application does not bind the applicant or the Insurer.

The undersigned further declares that any event taking place between the date this application was signed and the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any information in this application, will immediately be reported in writing to us and we may withdraw or modify any outstanding quotations and /or authorization or agreement to bind the insurance.

FRAUD NOTICES - FOR APPLICANTS OF THE FOLLOWING STATES

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading statement is guilty of a felony of the third degree.

KANSAS: A fraudulent insurance act means an act committed by any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer or purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of or the rating of, an insurance policy for commercial or personal insurance, or a claim of payment or other benefit pursuant to an insurance policy for personal or commercial insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty

not to exceed five thousand dollars and the stated value of the claim for each violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy, containing false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Applicant signature: _____ Title: _____

Agent/Broker: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone number: ( ) - _____ Date: _____

Ambulance and Emergency Technicians Application - Occurrence

VEHICLE SCHEDULE

Classifications: A – Ambulance PT – Paratransit/Wheelchair F – First Responder S – Service (all other units)

*Year	Make	Mfgr	Type 1, 11, 111 or other	Serial Number	Garage Location	Classification	Original Cost New	Current Value
1998 Example	Ford Example	Horton Example	Type 1 Example	1FTGSY1322311 Example	Kent, OH Example	A Example	$55,000 Example	$20,000 Example

Please duplicate form for additional vehicles

LOSS PAYEE-Vehicle Number: _____
Name: _____
Address: _____

LOSS PAYEE-Vehicle Number: _____
Name: _____
Address: _____

LOSS PAYEE-Vehicle Number: _____
Name: _____
Address _____

***Note:** Attach color photos of all vehicles 10 years or older

DRIVER SCHEDULE

Please list all drivers*

***Driver includes all personnel (full-time, part-time, volunteer, infrequent or incidental) who are authorized to operate the Insured's vehicles.**

Name	Full Date of Birth	Date Employed	3 Year Accident/Violation Record	Driver's License Number & State

Allied Health Care Providers Professional Liability Declarations

ZURICH

Policy Number: _____

Renewal Number: _____

INSURANCE COMPANY:	**AGENT**:

Named Insured:

Mailing Address:

Policy Period: From _____ To _____ At 12:01 A.M. Standard Time At Your Mailing Address Shown Above

IN RETURN FOR THE PAYMENT OF THE PREMIUM, AND SUBJECT TO ALL THE TERMS OF THIS POLICY, WE AGREE WITH YOU TO PROVIDE THE INSURANCE AS STATED IN THIS POLICY.

LIMITS OF INSURANCE

COVERAGE A

Each Medical Incident Limit _____

Individual Professional Liability Aggregate Limit (Coverage **A**) _____

COVERAGE B

Each Business Intity Incident Limit _____

Partnership, Limited Liability Company, Association Or Corporation

Professional Liability Aggregate Limit (Coverage **B**) _____

RETROACTIVE DATE (PR 00 06 ONLY)

This insurance does not apply to injury arising out of a "medical incident" or "business entity incident" which occurs before the retroactive date, if any, shown below.

Retroactive Date: _____

(Enter Date Or "None" If No Retroactive Date Applies)

DESCRIPTION OF BUSINESS

FORM OF BUSINESS:

☐ Individual ☐ Partnership ☐ Joint Venture ☐ Trust ☐ Limited Liability Company

☐ Organization, including a Corporation (But not including a Partnership, Joint Venture Or Limited Liability Company)

BUSINESS DESCRIPTION: _____

CLASSIFICATION AND PREMIUM				
CLASSIFICATION	**CODE NO.**	**PREMIUM BASE**	**RATE**	**ADVANCE PREMIUM**

Premium For Endorsements _____

State Tax Or Other (If Applicable) _____

_____

_____

Total Premium (Subject To Audit) _____

PREMIUM SHOWN IS PAYABLE: At Inception _____

At Each Anniversary _____

(if policy period is more than one year and premium is paid in annual installments)

AUDIT PERIOD (IF APPLICABLE)	☐ Annually	☐ Semi-Annually	☐ Quarterly	☐ Monthly

ENDORSEMENTS
ENDORSEMENTS ATTACHED TO THIS POLICY:

THESE DECLARATIONS, TOGETHER WITH THE COMMON POLICY CONDITIONS AND COVERAGE FORM(S) AND ANY ENDORSEMENT(S), COMPLETE THE ABOVE NUMBERED POLICY.

Date of Issue: Countersigned By _____

Authorized Representative

Volunteer Worker(s) Professional Liability Coverage

ZURICH

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the:

ALLIED HEALTH CARE PROVIDERS PROFESSIONAL LIABILITY COVERAGE FORM

A. Paragraph **1. b. (3)** of **Section I – Coverage A – Insuring Agreement – Individual Professional Liability** is replaced by the following:

1. Coverage A – Insuring Agreement – Individual Professional Liability

b. This insurance applies to injury only if:

(3) The injury arises out of the individual insured's profession as a licensed health care provider or out of a “volunteer worker”(s) acts or omissions within the scope of your authorization in the performance of duties related to the conduct of your practice; and

B. Paragraph **1.** of **Section II – Who Is An Insured** is amended to include, as an insured, your "volunteer workers", but only for acts or omissions within the scope of your authorization to perform duties related to the conduct of your practice.

C. The following is added to **Section III – Limits Of Insurance**:

7. Under Coverage **A**, a separate Aggregate Limit and a separate Each Medical Incident Limit (equal to the Aggregate Limit and Each Medical Incident Limit shown in the Declarations) each apply collectively to all insureds, other than Named Insureds.

D. With respect to "volunteer workers", the following is added to Paragraph **4.b. Other Insurance**, of **Section IV – Conditions**:

4. Other Insurance

b. Excess Insurance

This insurance is excess over any of the other insurance, whether primary, excess, contingent or on any other basis that is:

(1) Effective prior to the beginning of the policy period shown in the Declarations of this insurance and applies to injury on other than a claims-made basis, if:

(a) No Retroactive Date is shown in the Declarations of this insurance; or

(b) The other insurance has a policy period which continues after the Retroactive Date shown in the Declarations of this insurance; or

(2) Issued to a "volunteer worker".

When this insurance is excess, we will have no duty to defend that " volunteer worker" against any "suit" if any other insurer has a duty to defend that " volunteer worker" against that "suit". If no other insurer defends, we will undertake to do so, but we will be entitled to rights of that individual " volunteer worker" against all those other insurers.

When this insurance is excess over other insurance, we will pay, up to the applicable limits of insurance, the amount of the loss that exceeds the sum of the total amount that all such other insurance would pay for the loss in the absence of this insurance.

If other insurance is also excess, we will share the remaining loss with that other insurance.

E. The following definition is added to **Section VI - Definitions**:

"Volunteer Worker(s)" means a person(s) who:

a. Has achieved required professional certification;

b. Is not employed or compensated as a professional healthcare service provider;

c. Donates his or her work to you; and

d. Acts at your direction.

All other terms, conditions, provisions and exclusions of this policy remain unchanged.

Policy Number

SCHEDULE OF FORMS AND ENDORSEMENTS

Named Insured

Effective Date:

12:01 A.M., Standard Time

Agent Name

Agent No.

SERFF Tracking Number:	*ZURC-125376790*	*State:*	*Arkansas*
Filing Company:	*Empire Fire and Marine Insurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*CW PR 26276*		
TOI:	*17.2 Other Liability - Occurrence Only*	*Sub-TOI:*	*17.2022 Other*
Product Name:	*Professional Liability/Ambulance CW PR 26276*		
Project Name/Number:	*Professional Liability/Ambulance CW PR 26276/CW PR 26276*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ZURC-125376790*	*State:*	*Arkansas*
Filing Company:	*Empire Fire and Marine Insurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*CW PR 26276*		
TOI:	*17.2 Other Liability - Occurrence Only*	*Sub-TOI:*	*17.2022 Other*
Product Name:	*Professional Liability/Ambulance CW PR 26276*		
Project Name/Number:	*Professional Liability/Ambulance CW PR 26276/CW PR 26276*		

Supporting Document Schedules

		Review Status:	
Satisfied -Name:	Uniform Transmittal Document-Property & Casualty	Approved	12/07/2007

Comments:

Attachment:

NAIC Transmittal AR.pdf

Property & Casualty Transmittal Document

1. Reserved for Insurance Dept. Use Only

2. Insurance Department Use only	
a. Date the filing is received:	
b. Analyst:	
c. Disposition:	
d. Date of disposition of the filing:	
e. Effective date of filing:	
New Business	
Renewal Business	
f. State Filing #:	
g. SERFF Filing #:	
h. Subject Codes	

3.	Group Name Zurich North America	Group NAIC #
		212

4.	Company Name(s)	Domicile	NAIC #	FEIN #	State #
	Empire Fire & Marine Ins. Co.	NE	21326	47-6022701	

5.	Company Tracking Number	CW PR 26276

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Carole Amato 1400 American Lane	Analyst	847-413-5235	847-605-7768	carole.amato@zurichna.com
	Schaumburg, IL 60196				
7.	Signature of authorized filer		Carole Amato		
8.	Please print name of authorized filer		Carole Amato		

Filing information (see General Instructions for descriptions of these fields)

9.	**Type of Insurance (TOI)**	17			
10.	**Sub-Type of Insurance (Sub-TOI)**	Other			
11.	**State Specific Product code(s)(if applicable)[See State Specific Requirements]**				
12.	**Company Program Title (**Marketing title)	Professional Liability Endorsements - Ambulance Program			
13.	**Filing Type**	[ ] Rate/Loss Cost [ ] Rules [ ] Rates/Rules [**x**] Forms [ ] Combination Rates/Rules/Forms [ ] Withdrawal[ ] Other (give description)			
14.	**Effective Date(s) Requested**	New:	05-01-2008	Renewal:	05-01-2008
15.	**Reference Filing?**	[ ] Yes [ ] No			
16.	**Reference Organization (**if applicable)				
17.	**Reference Organization # & Title**				
18.	**Company's Date of Filing**				
19.	**Status of filing in domicile**	[ ] Not Filed [ ] Pending [ ] Authorized [ ] Disapproved			

Property & Casualty Transmittal Document—

20.	**This filing transmittal is part of Company Tracking #**	CW PR 26276

21.	**Filing Description** [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

Wwe are submitting a new, proprietary endorsement and application for use with the Ambulance Program.

EM 4656 (09-06) Volunteer Worker(s) Professional Liability Coverage
This endorsement will be used with the Allied Health Care Providers Coverage form to provide coverage for Volunteer Workers.

EM 2088 (04-07) Ambulance and Emergency Technicians Application – Occurrence
This application will be used when writing the Ambulance Program. It contains questions related to commercial auto and liability lines of business. We are submitting the form as it will be attached to the Professional Liability portion of the policy.

We will be using ISO Coverage forms and rules for this program. We will use ISO mandatory, State Amendatory endorsements.

With this filing, we are also including a Professional Liability Declarations page and a Schedule of Forms and Endorsements. These two forms may be used by other programs or policies as necessary:

- EM 3626 0906 Alliance Health Care Providers Professional Liability Declarations
- U-GL-619-A CW 1002 Schedule of Forms and Endorsements

Rules for this coverage are being submitted separately.

2.	**Filing Fees** (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #: EFT
Amount: 50.00

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

Effective March 1, 2007

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)
(Do not refer to the body of the filing for the forms listing, unless allowed by state.)

1.	**This filing transmittal is part of Company Tracking #**	CW PR 26276
2.	**This filing corresponds to rate/rule filing number** (Company tracking number of rate/rule filing, if applicable)	CW PR 26276

3.	**Form Name /Description/Synopsis**	**Form # Include edition date**	**Replacement Or withdrawn?**	**If replacement, give form # it replaces**	**Previous state filing number,** if required by state
01	Schedule of Forms and Endorsements	U-GU-619-A 10/02	[**x**] New Replacement [ ] Withdrawn		
02	Allied Health Care Providers Professional Liability Declarations	EM 36 26 09/06	[**x**] New [ ] Replacement [ ] Withdrawn		
03	Volunteer Worker(s) Professional Liability Coverage	EM 46 56 09/06	[**x**] New [ ] Replacement [ ] Withdrawn		
04	Ambulance and Emergency Technicians Application-Occurrence	EM 20 88 04/07	[**x**] New [ ] Replacement [ ] Withdrawn		
05			[ ] New [ ] Replacement [ ] Withdrawn		
06			[ ] New [ ] Replacement [ ] Withdrawn		
07			[ ] New [ ] Replacement [ ] Withdrawn		
08			[ ] New [ ] Replacement [ ] Withdrawn		
09			[ ] New [ ] Replacement [ ] Withdrawn		
10			[ ] New [ ] Replacement [ ] Withdrawn		